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No. 95-1118

IN THE

Supreme Court of the United States

OCTOBER TERM, 1995

BLUE CROSS & BLUE SHIELD UNITED OF WISCONSIN
AND
COMPCARE HEALTH SERVICES INSURANCE CORPORATION,
Petitioners,

v.

THE MARSHFIELD CLINIC
AND
SECURITY HEALTH PLAN OF WISCONSIN, INC.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AND BRIEF OF BLUE CROSS AND BLUE SHIELD ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Of Counsel:
ROGER G. WILSON
MARK A. ORLOFF
MARVIN C. REITER
Blue Cross and Blue Shield Association
676 North St. Clair Street
Chicago, Illinois 60611

JACK A. ROVNER
Counsel of Record for Amicus Curiae
Jack Rovner & Associates
1979 North Mill Street,
Suite 211
Naperville, Illinois 60563
(708) 416-4300
Fax (708) 416-4310
Attorneys for Amicus Curiae Blue Cross and Blue Shield Association

Dated: February 14, 1996

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MOTION OF BLUE CROSS AND BLUE SHIELD ASSOCIATION FOR LEAVE TO FILE BRIEF AS AMICUS CURIAE IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

Blue Cross and Blue Shield Association ("Association") respectfully moves, pursuant to Supreme Court Rule 37, for leave to file its brief as amicus curiae in support of the Petition for a Writ of Certiorari. The Association is an Illinois not-for-profit corporation. As the owner and licensor of the well-known Blue Cross® and Blue Shield® service marks for use by qualified health insurance plans and an active participant in America's health care delivery system, the Association has a vital interest in the competitive functioning of health care markets. The 67 independent Plans licensed by the Association provide prepaid, managed care

and other forms of health care financing to more than 65 million Americans. One in every four people in the United States with health insurance is covered by a licensed Plan. Petitioner Blue Cross & Blue Shield United of Wisconsin is the Association's licensee for the State of Wisconsin.

The Association's amicus brief brings a unique national and historical prospective to two issues presented by this case that are critical to competitive markets for the services of physicians and other health care providers in America:

> *First,* whether a dominant group medical practice like Respondent Marshfield Clinic may control the market price of physician services under the guise of a physician-controlled health care delivery system; and
>
> *Second,* whether such a dominant group medical practice may use most favored nation clauses to stabilize and inflate the market price of physician services.

In this case, a jury found that Respondent Marshfield Clinic used contracts with virtually every independent physician in North Central Wisconsin to fix and control the fees of these competing physicians in violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§1-2. Among the instruments used by Respondent to control physician fees are most favored nation clauses. Although the trial court sustained the jury's verdict as supported by substantial record evidence, the Seventh Circuit reversed the price-fixing violations. That action profoundly threatens competition in provider markets, to the detriment of the Association, the Plans and other health insurers and purchasers of provider services. The Association's amicus brief explains from its unique prospective why the Court should grant the Petition for a Writ of Certiorari to examine these important issues and correct the errors of the Seventh Circuit.

The Association requested the consent of the parties to file its amicus brief. Respondents refused. Because the issues addressed by the Association's amicus brief are so important to the interests

of purchasers of physician services, like the 67 licensed Plans and the 65 million Americans they serve, the Association asks the Court to grant this motion and accept its amicus brief.

Respectfully submitted,

JACK A. ROVNER
Counsel of Record for Amicus Curiae
Jack Rovner & Associates
1979 North Mill Street
Suite 211
Naperville, Illinois 60563
(708) 416-4300
Fax (708) 416-4310
Attorneys for Amicus Curiae Blue Cross and Blue Shield Association

Of Counsel:
ROGER G. WILSON
MARK A. ORLOFF
MARVIN C. REITER
Blue Cross and Blue Shield Association
676 North St. Clair Street
Chicago, Illinois 60611

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AMICUS CURIAE BRIEF OF BLUE CROSS AND BLUE SHIELD ASSOCIATION IN SUPPORT OF THE PETITION FOR WRIT OF CERTIORARI

INTEREST OF AMICUS CURIAE BLUE CROSS AND BLUE SHIELD ASSOCIATION

Blue Cross and Blue Shield Association ("Association") submits this amicus curiae brief in support of the Petition for a Writ of Certiorari of Blue Cross & Blue Shield United of Wisconsin ("Wisconsin Blue Cross"). The Association is an Illinois not-for-profit corporation that owns and licenses the Blue

Cross® and Blue Shield® service marks for use by qualified health insurance plans.[1] Wisconsin Blue Cross is the Association's licensee for the State of Wisconsin.

The 67 independent Plans licensed by the Association provide health insurance to more than 65 million Americans. They annually purchase tens of billions of dollars of health care services for these subscribers. To fulfill their missions as licensees of the Association to provide affordable health benefits to the nation's consumers, the Plans offer a variety of health care financing vehicles, including prepaid service benefits, indemnity insurance, health maintenance organizations ("HMOs"), preferred provider organizations ("PPOs"), and point of service coverage ("POS"). Access to competitive health care provider markets is crucial to the economic viability of and consumer choice among these health care financing mechanisms. The Association and the licensed Plans therefore want and need competitive physician markets.

SUMMARY OF REASONS FOR GRANTING THE WRIT

The Writ should issue because the opinion of the Seventh Circuit in this case threatens competitive markets for physician services in at least two ways. First, the opinion appears to condone physician price-fixing when done under the guise of a physician-controlled health care delivery network. That is inconsistent with this Court's holding in *Arizona v. Maricopa County Medical Society*, 457 U.S. 332 (1982), and should be corrected. Second, the opinion appears to exonerate use of most favored nation clauses by physicians buying the services of competing providers, without regard to whether such competitors are using these arrangements to control price. That ignores the danger to price competition when competing physicians use these arrangements to buy from each other, as their incentives are to stabilize and inflate, not reduce, price.

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[1] A list of the licensed Plans appears in the Appendix to this brief.

REASONS FOR GRANTING THE WRIT

I. *The Seventh Circuit's Treatment of the Jury's Finding of Physician Price-Fixing and the Evidence that Sustained It.*

Respondent Marshfield Clinic is a group medical practice owned by the 400 physicians it employs. (Pet. App. 2a) It is the dominant provider of physician services in North Central Wisconsin. (Pet. App. 2a-3a, 7a) It owns the dominant HMO in North Central Wisconsin — Respondent Security Health Plan of Wisconsin, Inc. ("Security"). (Pet. App. 3a, 27a) Marshfield Clinic directly or through Security contracts with virtually every independent physician in North Central Wisconsin — nearly 900 otherwise competing physicians — to form a delivery network of physician services. (Pet. App. 3a; Tr. 746-50; Tr. Ex. 10222, 10344-52)

The jury found that these physician affiliation contracts are vehicles for Marshfield Clinic to fix and control the fees of the competing physicians in violation of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1-2. (Pet. App. 76a) The trial court confirmed that the record evidence sustained the jury's finding: "There was evidence of price-fixing between Marshfield and its affiliated providers. The affiliated providers had only one fee schedule for both Security and non-Security patients, (Tr. at 887-889), and Marshfield approved or disapproved it. (Tr. 887-889.)" (Pet. App. 36a) The trial court observed that the combination of Marshfield Clinic and the 900 competing affiliated providers "is not a straight buyer-seller relationship, it is a relationship of competing sellers." (Pet. App. 36a) The result has been "supra-competitive prices and the elimination or reduction of competition" to the detriment of Wisconsin Blue Cross and other purchases of physician services in North Central Wisconsin. (Pet. App. 36a)

The Seventh Circuit brushed aside the jury's price-fixing verdict and the evidence supporting it with the bare statement that "[t]he only evidence of collusion is that the Clinic, when buying

services from the affiliated physicians either directly or through Security, would not pay them more than what these physicians charge their other patients." (Pet. App. 16a) The Seventh Circuit paid no attention to the evidence highlighted by the trial court "that price competition between the affiliates and Marshfield is controlled by Marshfield [which] obtains the fee schedules of its affiliates and approves or disapproves them." (Pet. App. 32a)[2]

Thus narrowing the issue to the legality of most favored nation clauses, despite the evidence of broader price control by Marshfield Clinic, the Seventh Circuit decreed that such clauses are "the sort of conduct that the antitrust laws seek to encourage" and "not price-fixing." (Pet. App. 17a) It made no effort to determine if the use of such clauses by physicians buying the services of competing physicians could serve as price stabilization mechanisms contrary to the interests of the ultimate purchasers of physician services, like the Association's licensed Plans.

II. *The Writ Should Issue to Affirm the Continued Application of* Maricopa *to Provider Price-Fixing Arrangements.*

The Seventh Circuit's rejection of the physician price-fixing found by the jury and sustained by the trial court is inconsistent with this Court's teachings in *Arizona v. Maricopa County Medical Society,* 457 U.S. 332 (1982). The Writ should issue to address and correct this inconsistency.

Maricopa presented the question whether "agreements among competing physicians setting, by majority vote, the maximum fees that they may claim in full payment for health services provided

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[2]This alone is sufficient reason for the Writ to issue. As it was reviewing a jury verdict, the Seventh Circuit was constitutionally bound by the jury's determinations as long as there is evidence in the record to support them. *Atlantic & Gulf Stevedores v. Ellerman Lines, Ltd.*, 369 U.S. 355, 358-59 (1962) ("neither we nor the Court of Appeals can redetermine facts found by the jury any more than the District Court can predetermine them"); *Tennant v. Peoria & Pekin Union Ry.*, 321 U.S. 29, 35 (1944) ("Courts are not free to reweigh the evidence and set aside the jury verdict merely because the jury could have drawn different inferences or conclusions, or because judges feel that other results are more reasonable").

to policyholders of specified insurance plans" violated *per se* Section 1 of the Sherman Act. 457 U.S. at 335-36. This Court answered with a definitive yes.

The parallels between the *Maricopa* facts and the facts of this case are striking. In *Maricopa,* about 70% of the competing physicians in two Arizona counties, by contracting with each other through "foundations for medical care," were able collectively to control their fees. 457 U.S. at 339-40. In this case, Marshfield Clinic — a physicians' group practice — by contracting directly or through its Security HMO with nearly every independent competing physician in North Central Wisconsin, is able to control the fees of those competing physicians. (Pet. App. 36a) In *Maricopa,* the physicians participating in the foundations had no financial interest in the foundations; the foundations were vehicles to sell their services at collectively fixed prices. 457 U.S. at 356. In this case, the independent physicians under contract with Marshfield Clinic or Security have no financial interest in either; the affiliation agreements are vehicles to sell their services to Marshfield Clinic and Security *and, critically,* for Marshfield Clinic to control the fees of these physicians generally. That is what the jury found and what the trial court confirmed that the evidence sustained. (Pet. App. 32a, 36a)

None of this was addressed by the Seventh Circuit before it decreed that Marshfield Clinic's activities are "not price-fixing." (Pet. App. 17a) Worse in this context, the Seventh Circuit's opinion appears to *encourage* the kind of illegal collusion found by the jury when it suggests that "[o]nly as part of a large and sophisticated medical enterprise such as the Marshfield Clinic can [independent physicians] practice modern medicine in rural Wisconsin." (Pet. App. 10a)

The Seventh Circuit may have turned a blind eye to the antitrust dangers inherent in physician involvement in financing organizations, but the Association and the licensed Plans have not. In contrast to historical origins, each organization (including Wisconsin Blue Cross), in order to be licensed to use the Blue

Cross® and Blue Shield® service marks, now must not be controlled by any special interest group and must maintain a public majority on its governing board. These changes are consistent with the teachings of this Court, other Circuits and the federal antitrust enforcement agencies. In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 232 n.40 (1979), this Court observed:

> "[E]xempting provider agreements from the antitrust laws would be likely in at least some cases to have serious anticompetitive consequences. Recent studies have concluded that physicians and other health-care providers typically dominate the boards of directors of Blue Shield plans. Thus, there is little incentive on the part of Blue Shield to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level. This domination of Blue Shield by providers is said to have resulted in rapid escalation of health-care costs to the detriment of consumers generally."

Cf. Union Labor Life Insurance Co. v. Pireno, 458 U.S. 119, 133 (1982) (Provider-controlled peer review panel used to review provider pricing carries "the potential to restrain competition").

Courts of the Second, Fourth, Fifth, Sixth and Ninth Circuits have warned of such dangers in permitting Sherman Act claims to proceed when providers dominate the fee-setting mechanisms. *E.g., Virginia Academy of Clinical Psychologists v. Blue Shield of Virginia*, 624 F.2d 476 (4th Cir. 1980) (Requirement that psychologists bill through physicians to receive reimbursement from insurer an unreasonable trade restraint because the financing organizations "are combinations of physicians, operating under the direction and control of their physician members"), *cert. denied*, 450 U.S. 916 (1981); *St. Bernard General Hospital, Inc. v. Hospital Service Association of New Orleans, Inc.*, 712 F.2d 978 (5th Cir. 1983) (Reversing dismissal of price-fixing claims because, in part, "the participating hospitals enjoyed effective control of the Blue Cross board"), *cert. denied*, 466 U.S. 970 (1984); *Glen Eden Hospital, Inc. v. Blue Cross & Blue Shield of*

Michigan, Inc., 740 F.2d 423, 430 (6th Cir. 1984) (Reversing summary judgment for defendants with comment, "if Glen Eden is able to demonstrate control by other hospitals over the reimbursement payments Blue Cross is willing to offer it, the necessary agreement or conspiracy to fix prices of a competitor will be established"); *Hahn v. Oregon Physicians' Service*, 868 F.2d 1022 (9th Cir. 1988) (Reversing summary judgment for defendant because "whether practitioners sharing substantially similar economic interests collectively exercised control of a plan under whose auspices they have reached agreements which work to the detriment of competitors" is material fact issue), *cert. denied*, 493 U.S. 846 (1989); *Addino v. Genesee Valley Medical Care, Inc.*, 593 F. Supp. 892 (W.D.N.Y. 1984) (Summary judgment finding price-fixing because physicians "have the power to control the rate setting mechanism"). *See also Ratino v. Medical Service*, 718 F.2d 1260, 1270-71 (4th Cir. 1983) (dicta) ("If . . . in effect the physicians control the customary fee, under *Maricopa* [a court] must find such practice *per se* illegal").

The Department of Justice and Federal Trade Commission have also expressed concern about the risks to competitive pricing when, as was found in this case, independent providers collectively dominate provider pricing structures. *See, e.g.*, Department of Justice and Federal Trade Commission Statements of Enforcement Policy and Analytical Principles Relating to Health Care and Antitrust, *Statement 9 — Analytical Principles Relating to Multiprovider Networks* (Sept. 24, 1994).

The analysis in *St. Bernard Hospital* is particularly apt to the facts in this case. The price-fixing alleged in *St. Bernard Hospital* was an effort by the competing hospitals to control the pricing of other hospitals with which they competed. 712 F.2d at 987. That is precisely the conduct that the jury found Marshfield Clinic to have engaged in with respect to the competing affiliated physicians. According to the Fifth Circuit, that conduct is "a more egregious scheme of anticompetitive behavior than even *Maricopa*" because "[i]t imposes burdens on outsiders but not upon

the insiders who create the rules." *Id.* The Seventh Circuit's opinion ignores all these aspects of the Marshfield Clinic price-fixing found by the jury and sustained by the trial court on the evidence.

The continued evolution of efficient, cost-effective health care markets requires that courts stay vigilant against provider-controlled vehicles for fixing and controlling physician fees. The Seventh Circuit's opinion abandons that vigilance. This Court should grant the petition to reverse that mistake.

III. *The Writ Should Issue to Address the Proper Antitrust Treatment of Physician Use of Most Favored Nation Clauses in the Purchase of Competitors' Services.*

The Seventh Circuit's perfunctory approval of Marshfield Clinic's use of most favored nation clauses in the affiliated physician contracts failed to address the danger to competitive pricing such clauses pose when part of arrangements by which one group of physicians buys the services of competing physicians. This Court's insight in *Royal Drug* that, when providers control the reimbursement pricing, "there is little incentive . . . to minimize costs, since it is in the interest of the providers to set fee schedules at the highest possible level," 440 U.S. at 232 n.40, fits precisely to this case. The facts of this case, thus, provide the ideal context for this Court to address and clarify the standards for determining the legality of most favored nation clauses under the Sherman Act.

The use of most favored nation clauses in health care markets has increasingly come under antitrust attack, and the question is ripe for this Court's review. When used by buyers, like the Association's licensed Plans which are not controlled by the providers whose services are being purchased, the courts have generally upheld these clauses as enhancing competition and consumer welfare; this has been the result even when such buyers are presumed to have monopsony power. *E.g., Ocean State Physicians Health Plan Inc. v. Blue Cross & Blue Shield of Rhode*

Island, 883 F.2d 1101, 1110 (1st Cir. 1989), *cert. denied,* 494 U.S. 1027 (1990); *Kipsap Physicians Service v. Washington Dental Service,* 671 F. Supp. 1267, 1269 (W.D. Wash. 1987); *Blue Cross & Blue Shield of Michigan v. Michigan Association of Psychotherapy Clinics,* 1980-2 Trade Cas. ¶ 63,351 (E.D. Mich. 1980); *Willamette Dental Group, P.C. v. Oregon Dental Service Corp.,* 130 Or. App. 487, 882 P.2d 637 (1994), *petition for review denied,* 320 Or. 508, 888 P.2d 569 (1995). *But cf. Reazin v. Blue Cross & Blue Shield of Kansas, Inc.,* 899 F.2d 951 (10th Cir.) (most favored nation clause considered "as evidence of, or as contributing to Blue Cross market or monopoly power," but "whether use of the most favored nations clause could itself violate section 2" not reached), *cert. denied,* 497 U.S. 1005 (1990). These decisions (except *Reazin*) are sound as a monopolist (or monopsonist) is entitled to compete, including obtaining the lowest prices possible from its suppliers to enhance its ability to do so. *See Ocean State Physicians Health Plan,* 883 F.2d at 1110 ("Section 2 does not prohibit vigorous competition on the part of a monopoly"); *Ball Memorial Hospital, Inc. v. Mutual Hospital Insurance, Inc.,* 784 F.2d 1325, 1339 (7th Cir. 1986) (rejecting argument that "firm with a large market share has an obligation not to augment that share at the expense of rivals" because "even a monopolist may bargain hard"); *Foremost Pro Color, Inc. v. Eastman Kodak Co.,* 703 F.2d 534, 544-46 (9th Cir.) ("monopolist, no less than any other competitor, is permitted and indeed encouraged to compete aggressively"), *cert. denied,* 465 U.S. 1038 (1984).

The current Department of Justice has undertaken to attack most favored nation clauses, whether used by provider-controlled or by independent health care buyers, on the premise that the clauses can be vehicles to stabilize price or bar competitive entry. *See, e.g., United States v. Delta Dental Plan of Arizona, Inc.,* 1995-1 Trade Cas. (CCH) ¶ 71,048 (D. Ariz. 1995) (consent decree); *United States v. Oregon Dental Service,* 1995-2 Trade Cas. (CCH) ¶ 71,062 (N.D. Cal. 1995) (consent decree); *United States v. Vision Service Plan,* No. 1:49CV02693 (D.D.C.

Dec. 15, 1994) (complaint and proposed consent decree). Together with the Federal Trade Commission, the Department of Justice supported rehearing of the Seventh Circuit's decision in this case, *inter alia,* because of its concern that the opinion's exoneration of most favored nation clauses "may be misunderstood as a conclusion that they necessarily pass muster under the Sherman Act or that an intent 'to minimize the cost' [citation omitted] of physicians' services is necessarily determinative." (Pet. App. 72a).

The Association agrees that most favored nation clauses can interfere with price competition *when used by competing health care providers to buy each other's services,* as occurred in this case. In this case, the clause provided competing physicians with a powerful instrument for stabilizing and controlling physician prices generally in North Central Wisconsin. The jury found that Marshfield Clinic used the clause with that effect. That finding is consistent with the expectation noted by this Court in *Royal Drug*, 440 U.S. at 232 n.40, because Marshfield Clinic's incentives and that of each of the competing affiliated physicians that contracted with it are to maintain inflated prices, to the detriment of the ultimate purchasers like Wisconsin Blue Cross. *See* 6 Phillip E. Areeda, *Antitrust Law* § 1435e, at 229-31 (1986) (observing that most favored nation clauses used by competitors can "facilitate tacit price coordination"). The Seventh Circuit paid no heed to that circumstance. That is why the Association believes that the Seventh Circuit erred in its perfunctory approval of Marshfield Clinic's use of the clauses in its affiliation contracts with competing physicians.

On the other hand, the Association believes that the current Department of Justice has gone far beyond *that* danger to attack legitimate uses of the clause by health care buyers, like the licensed Plans, that are independent of the providers whose services they purchase. In doing so, the current Department of Justice has put itself at odds with *Ocean State Physicians Health Plan* and the other cases sustaining these clauses when used by

legitimate buyers, is interfering with the competitive workings of the negotiations between health care providers and buyers like the licensed Plans that are not provider controlled, and is encouraging providers to exercise their market power to price discriminate among buyers with impunity.

The Association urges that the Writ issue so that this Court may analyze and clarify the correct application of antitrust principles to most favored nation clauses. The Association believes that the Seventh Circuit had it wrong by being too narrow, while the current Department of Justice has it wrong by being too broad. By issuing the Writ in this case, this Court can set the correct parameters for analyzing the competitive effects of most favored nation clauses and help ensure that future courts, enforcement agencies and health care industry participants get it right.

CONCLUSION

Competition is forcing health care markets toward more efficient and cost-effective delivery mechanisms. Unfortunately, the Seventh Circuit's opinion in this case endangers the continuation of that competition by giving a wink to provider price-fixing that this Court held illegal *per se* in *Maricopa* and a nod to the inherent danger of provider use of most favored nation clauses in agreements with competing providers. The Writ should issue so that this Court can address and correct these critical errors that endanger consumer welfare and the competitive functioning of health care markets.

Respectfully submitted,

JACK A. ROVNER
Counsel of Record for Amicus Curiae
Jack Rovner & Associates
1979 North Mill Street
Suite 211
Naperville, Illinois 60563
(708) 416-4300
Fax (708) 416-4310
Attorneys for Amicus Curiae Blue Cross and Blue Shield Association

Of Counsel:
ROGER G. WILSON
MARK A. ORLOFF
MARVIN C. REITER
Blue Cross and Blue Shield Association
676 North St. Clair Street
Chicago, Illinois 60611

Dated: February 14, 1996

APPENDIX

Licensed Plans of the Blue Cross and Blue Shield Association

ALABAMA	Blue Cross and Blue Shield of Alabama, Birmingham
ALASKA	Premera, Seattle
ARIZONA	Blue Cross and Blue Shield of Arizona, Inc., Phoenix
ARKANSAS	Arkansas Blue Cross and Blue Shield, Little Rock
CALIFORNIA	Blue Cross of California, Woodland Hills California Physicians' Service, San Francisco
COLORADO	Rocky Mountain Hospital and Medical Service, Denver
CONNECTICUT	Blue Cross & Blue Shield of Connecticut, Inc., North Haven
DELAWARE	Blue Cross & Blue Shield of Delaware, Inc., Wilmington
DISTRICT OF COLUMBIA	Group Hospitalization and Medical Services, Inc., Washington
FLORIDA	Blue Cross and Blue Shield of Florida, Inc., Jacksonville
GEORGIA	Blue Cross and Blue Shield of Georgia, Inc., Atlanta
HAWAII	Hawaii Medical Service Association, Honolulu
IDAHO	Blue Cross of Idaho Health Service, Inc., Boise Medical Service Bureau of Idaho, Inc., Lewiston
ILLINOIS	Health Care Service Corporation, a Mutual Legal Reserve Company, Chicago

INDIANA and KENTUCKY	Associated Insurance Companies, Inc., Indianapolis
IOWA	IASD Health Services Corp., Des Moines
KANSAS	Blue Cross and Blue Shield of Kansas, Inc., Topeka
LOUISIANA	Louisiana Health Service & Indemnity Company, Baton Rouge
MAINE	Associated Hospital Service of Maine, Portland
MARYLAND	Blue Cross and Blue Shield of Maryland, Inc., Baltimore
MASSACHUSETTS	Blue Cross and Blue Shield of Massachusetts, Inc., Boston
MICHIGAN	Blue Cross and Blue Shield of Michigan, Detroit
MINNESOTA	Aware Integrated, Inc., St. Paul
MISSISSIPPI	Blue Cross & Blue Shield of Mississippi, Inc., Jackson
MISSOURI	Blue Cross and Blue Shield of Kansas City, Kansas City Blue Cross and Blue Shield of Missouri, St. Louis
MONTANA	Blue Cross and Blue Shield of Montana, Inc., Helena
NEBRASKA	Blue Cross and Blue Shield of Nebraska, Omaha
NEVADA	Blue Cross and Blue Shield of Nevada, Reno
NEW HAMPSHIRE	New Hampshire-Vermont Health Service, Manchester
NEW JERSEY	Blue Cross and Blue Shield of New Jersey, Inc., Newark
NEW MEXICO	New Mexico Blue Cross & Blue Shield, Inc., Albuquerque

NEW YORK	Blue Cross and Blue Shield of Central New York, Inc., Syracuse
	Blue Cross and Blue Shield of Utica-Watertown, Inc., Watertown
	Blue Cross and Blue Shield of Western New York, Inc., Buffalo
	Empire Blue Cross and Blue Shield, New York City
	The Finger Lakes Companies, Inc., Rochester
NORTH CAROLINA ...	Blue Cross and Blue Shield of North Carolina, Durham
NORTH DAKOTA	Blue Cross Blue Shield of North Dakota, Fargo
OHIO	Blue Cross & Blue Shield Mutual of Ohio, Cleveland
	The Community Mutual Insurance Company, Cincinnati
OKLAHOMA	Group Health Service of Oklahoma, Inc., Tulsa
OREGON	Blue Cross and Blue Shield of Oregon, Portland
PENNSYLVANIA	Capital Blue Cross, Harrisburg
	Hospital Service Association of Northeastern Pennsylvania, Wilkes Barre
	Independence Blue Cross, Philadelphia
	Medical Service Association of Pennsylvania, Camp Hill
	Veritus, Inc., Pittsburgh
PUERTO RICO	La Cruz Azul de Puerto Rico, San Juan
	Seguros de Servicio de Salud de Puerto Rico, Inc., San Juan
RHODE ISLAND	Blue Cross & Blue Shield of Rhode Island, Providence
SOUTH CAROLINA ...	Blue Cross and Blue Shield of South Carolina, Columbia
SOUTH DAKOTA	South Dakota Medical Service, Inc., Sioux Falls

TENNESSEE	Blue Cross and Blue Shield of Tennessee, Chattanooga Memphis Hospital Service and Surgical Association, Inc., Memphis
TEXAS	Blue Cross and Blue Shield of Texas, Inc., Dallas
UTAH	Blue Cross and Blue Shield of Utah, Salt Lake City
VERMONT	Vermont Health Service Corporation, Montpelier
VIRGINIA	Blue Cross and Blue Shield of Virginia, Richmond
WASHINGTON	King County Medical Blue Shield, Seattle Pierce County Medical Bureau, Inc., Tacoma Premera, Seattle Washington Physicians Service, Inc., Seattle
WEST VIRGINIA	Mountain State Blue Cross & Blue Shield, Inc., Charleston
WISCONSIN	Blue Cross & Blue Shield United of Wisconsin, Milwaukee
WYOMING	Blue Cross and Blue Shield of Wyoming, Cheyenne